Massachusetts STD, HIV/AIDS and Viral Hepatitis Surveillance Report: 2006

Massachusetts Department of Public Health

Bureau of Communicable Disease Control

Division of STD Prevention and HIV/AIDS Surveillance
Division of Epidemiology and Immunization

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Massachusetts Department of Public Health

INTRODUCTION

This report describes recent disease trends in sexually transmitted diseases (STDs), viral hepatitis and HIV/AIDS in Massachusetts. Detailed STD, viral hepatitis, and HIV/AIDS data by city and town can be accessed on the Internet at www.mass.gov/dph/cdc/std or http://www.mass.gov/dph/cdc/aids/.

In addition to overall trends in STDs, HIV/AIDS and viral hepatitis, this summary provides a description of their impact on special populations: adolescents and young adults, women, and men who have sex with men (MSM). Certain racial/ethnic health disparities have also been highlighted.

This report is intended to be a user-friendly and easy-to-read reference for health care providers, local health departments and community-based organizations. Its goal is to enhance understanding of the public health importance of STDs, HIV/AIDS and viral hepatitis in Massachusetts. MDPH contact information and website resources are available on page 22.

Additionally, page 20 includes a description of the strengths and limitations of the surveillance data, as well as notes on how to interpret STD, HIV/AIDS and viral hepatitis data.

Unless otherwise noted, all incidence calculations represent crude rates. The source for all denominator data is the U.S. Census, 2000. All data reported are current as of December 1, 2007. All information on STD cases reflect year of report. Due to reporting delays related to the transition from code-base to name-based reporting of HIV cases, all HIV/AIDS data reflect HIV diagnosed through 2005.

ACKNOWLEDGEMENTS

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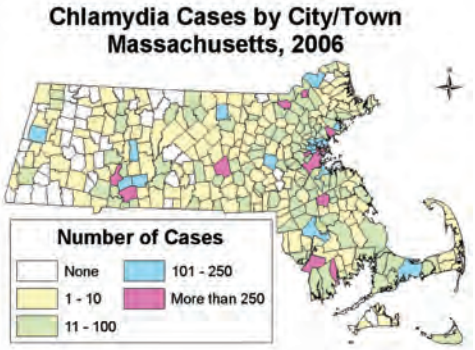
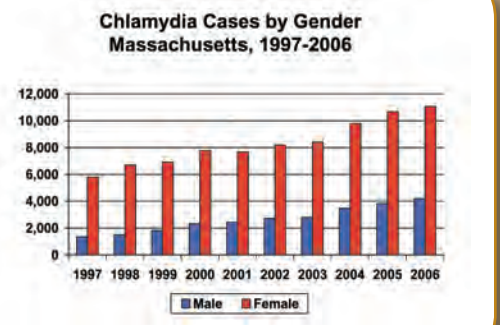
CHLAMYDIA

The overall number of reported chlamydia infections in Massachusetts in 2006 was 15,252. Chlamydia infection is widely distributed in Massachusetts.

Chlamydia case and incidence data by city and town are available online at www.mass.gov/dph/cdc/std.

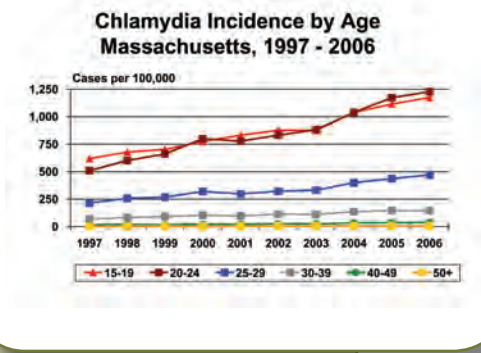




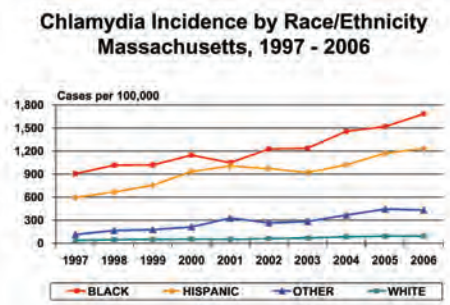
The total number of reported chlamydia infection cases in Massachusetts has more than doubled in the past ten years from 7,151 in 1997 to 15,276 in 2006.

Of the total reported cases in 2006, 4,191 were among men and 11,061 were among women. The greater number of chlamydia cases among women is partly attributable to a higher level of screening in women as compared to men.

In 2006, the incidence of chlamydia infection in Massachusetts among adolescents (ages 15-19) and young adults (ages 20-24) exceeded 1,000 per 100,000. This contrasts with the overall Massachusetts chlamydia infection rate of 240.2 per 100,000. (Ages 15-19: 1,174 per 100,000; Ages 20-24: 1,228 per 100,000)



Historically, communities of color have been disproportionately affected by STDs. In 2006, compared to whites, the incidence of reported chlamydia infections in Massachusetts was 18.1 times higher in blacks and 13.2 times higher in Hispanics.



INFERTILITY PREVENTION PROJECT

Since 1997, the Division of STD Prevention has participated in a Centers for Disease Control (CDC)-funded Infertility Prevention Project. The goal of this project is to reduce infertility and other health consequences of chlamydia infection through increased screening and treatment of women who are at high-risk for infection.

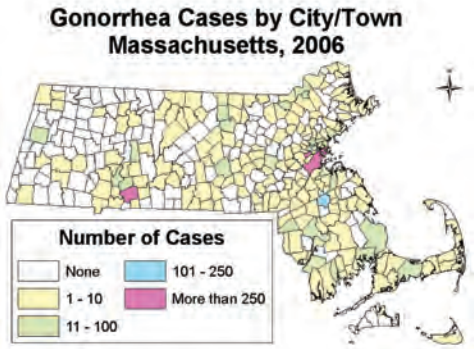
In 2006, as part of the Infertility Prevention Project, 22,756 specimens were tested for chlamydia infection. Tests results from participating sites have yielded the following:

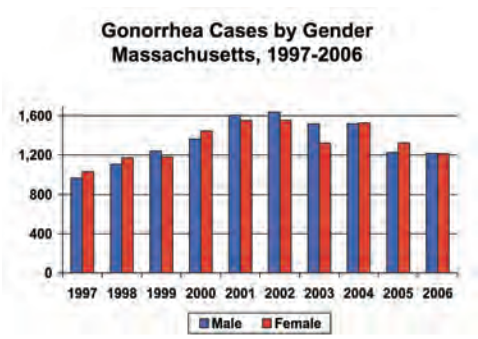
	PERCENT POSITIVE FOR *CHLAMYDIA TRACHOMATIS*	
Site Type (number tested)	**Females**	**Males**
School Based Health Centers (n = 838)	5.9%	10.2%
County Jails (n = 3195)	6.4%	7.2%
Family Planning Clinics (n = 9101)	4.4%	14.6%
STD Clinics (n = 8775)	7.3%	9.3%
Department of Youth Services (n = 1339)	6.7%	2.8%

GONORRHEA

The overall number of reported cases of gonorrhea in Massachusetts in 2006 was 2,428 cases. Although gonorrhea is widely distributed in Massachusetts, cases are concentrated in urban locations.

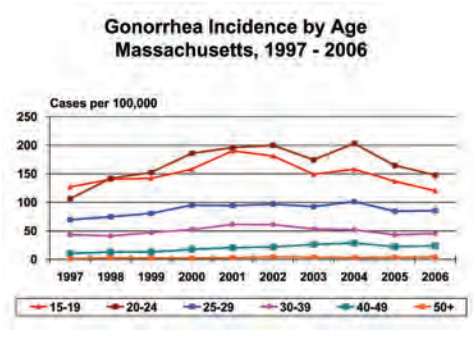
Gonorrhea case and incidence data by city and town are available online at www.mass.gov/dph/cdc/std.





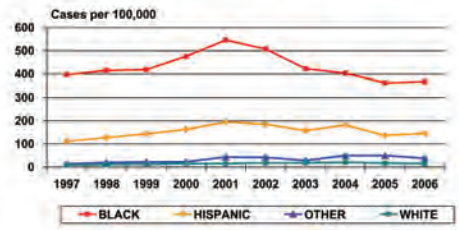
Massachusetts experienced an increase in reported gonorrhea cases from 1997-2002, followed by a decline from 2003-2006. Of the 2,428 total cases in 2006, 1,212 were in women and 1,216 were in men.

The incidence of gonorrhea in Massachusetts is highest among young adults (ages 20-24), followed by adolescents (ages 15-19). Compared to the state-wide incidence (38.2 per 100,000) of gonorrhea, the incidence was 3.2 times higher for adolescents and 3.9 times higher for young adults.



In 2006, compared to whites, the reported gonorrhea incidence in Massachusetts was 26.3 times higher in blacks and 10.4 times higher in Hispanics.

The disparity in gonorrhea incidence in Massachusetts reflects that at a national level, where the incidence is 18 times higher in blacks, and 2 times higher in Hispanics, when compared to whites. (Source: CDC. *Sexually Transmitted Disease Surveillance, 2005.* Atlanta, GA: U.S. Department of Health and Human Services, November 2006.)



EMERGING TRENDS IN ANTIBIOTIC RESISTANT GONORRHEA

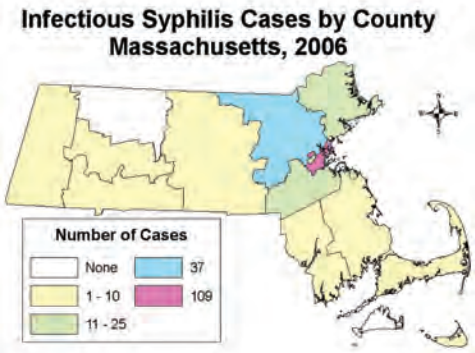
Quinolone-resistant *Neisseria gonorrhoeae* (QRNG) is a strain of bacteria that causes gonorrhea and may not be cured by standard oral antibiotic therapies. QRNG often requires more aggressive approaches to diagnosis and treatment.

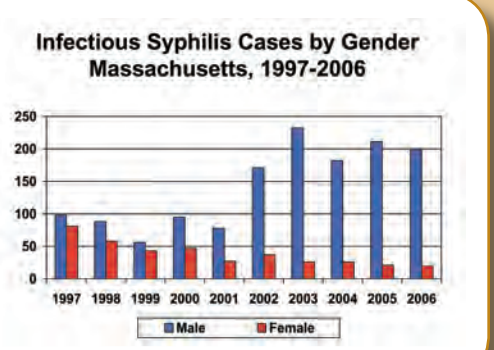
Results from the QRNG Prevalence Monitoring Project at the MDPH State Laboratory Institute indicate that the prevalence of QRNG continues to rise in Massachusetts. The proportion of QRNG among positive gonorrhea cultures increased from 13.5% in 2003 to 32.5% in 2006. Ninety-seven percent of QRNG cases were identified among men, and 84% of the men who tested positive for QRNG self-identified as men who have sex with men (MSM).

SYPHILIS

In 2006, there were 218 reported infectious primary, secondary and early latent syphilis cases in Massachusetts. Although infectious syphilis cases have been reported in almost all counties, the majority of cases were reported in Suffolk County.

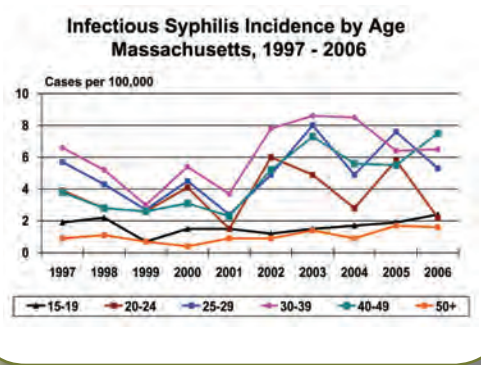
Infectious syphilis case and incidence data by city and town are available online at www.mass.gov/dph/cdc/std.



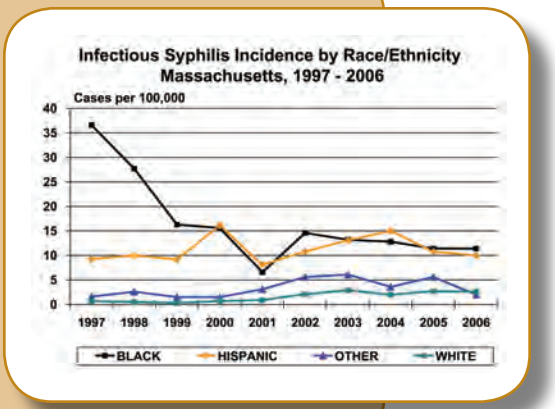


In Massachusetts, the male-to-female ratio of infectious syphilis cases changed from 1.2 to 1 in 1997, to 9.9 to 1 in 2006. This shift reflects an increase in the number of infectious syphilis cases diagnosed in men who have sex with men. This trend has also been observed in other regions of the United States.

In contrast to chlamydia infection and gonorrhea, which tend to occur more frequently among adolescent and young adults, infectious syphilis is more commonly reported in people over age twenty-five years.



In 2006, compared to whites, the reported infectious syphilis incidence in Massachusetts was 4.4 times higher in blacks and 3.8 times higher in Hispanics.



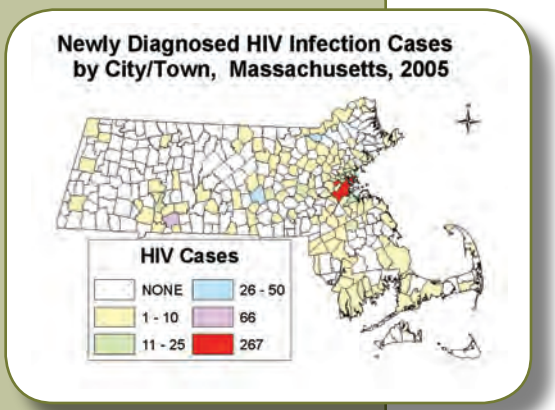
SYPHILIS IN MEN WHO HAVE SEX WITH MEN (MSM)

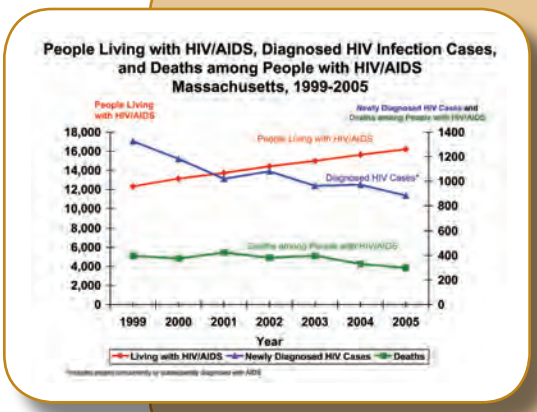
In Massachusetts, MSM represent a higher-risk group for infectious syphilis. Of the 218 reported infectious syphilis cases in 2006, 156 (72%) were in MSM. Forty-seven percent (74/156) of the MSM with infectious syphilis disclosed that they were co-infected with HIV. The majority (51%, 80/156) of the infectious syphilis cases in MSM were reported in Suffolk county.

Transmission of syphilis can occur between men through unprotected oral and anal sex. Additional information and resources regarding MSM and STDs is available online at www.gettestedboston.org.

Of the 351 cities and towns in Massachusetts, 135 (38.5%) had at least one reported newly diagnosed HIV infection in 2005. The majority of newly identified HIV infections were reported in large urban areas.

2005 HIV case and incidence data by city and town are available online at www.mass.gov/dph/cdc/aids. Additional information is available through the MDPH HIV/AIDS Epidemiologic Profile at the same weblink.

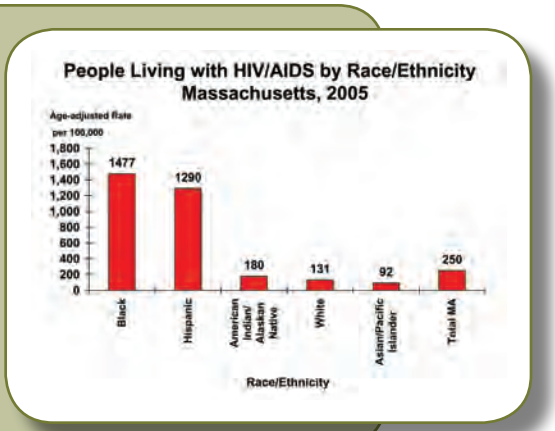




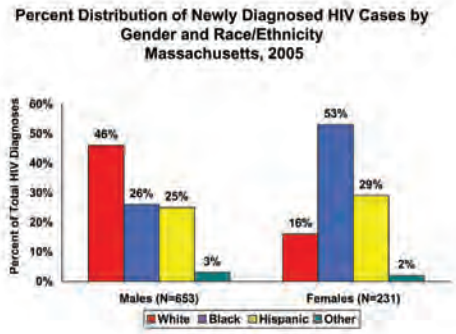
In 2005 there were 884 reported, newly diagnosed, HIV infections and 300 deaths among people with HIV/AIDS in Massachusetts.

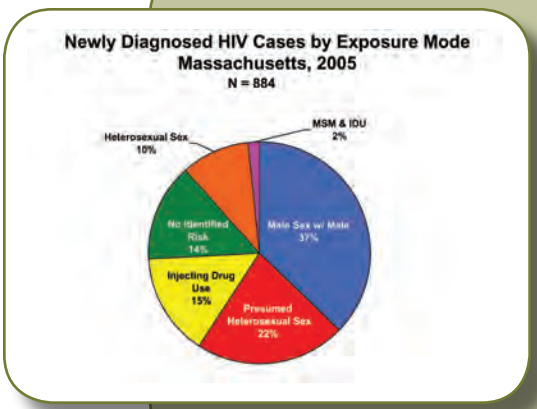
The number of people known to be living with HIV/AIDS in Massachusetts has increased from 12,325 in 1999 to 16,217 in 2005. This trend is attributable to both the introduction of highly active antiretroviral therapy (that helps people live longer) and a general leveling off of newly diagnosed HIV infections.

In Massachusetts, in 2005, the prevalence rate of people living with HIV/AIDS was highest among blacks and Hispanics. As compared to whites, the rate of people living with HIV/AIDS was 11.3 times higher among blacks and 9.9 times higher among Hispanics.



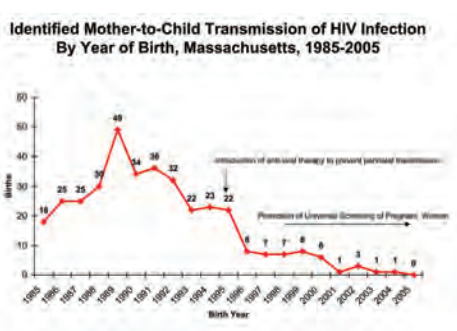
In 2005, of the 884 newly diagnosed HIV infections in Massachusetts, 653 (74%) were in men and 231 (26%) were in women. Most of newly diagnosed HIV infections in men were in white men, and the majority of newly diagnosed HIV infections in women were in black women.

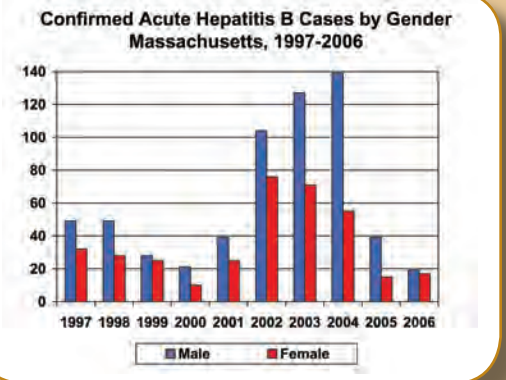




In 2005, the primary exposure modes reported among newly diagnosed HIV cases in Massachusetts were male with male sex (37%), presumed heterosexual sex (22%), and heterosexual sex (10%).

Since the mid-1990's Massachusetts has experienced a dramatic reduction in mother-to-child transmission of HIV infection, with no HIV-infected newborns identified in 2005, thus far. This success is attributed to improvements in HIV screening during pregnancy and the treatment of HIV-infected women with antiretroviral therapy.

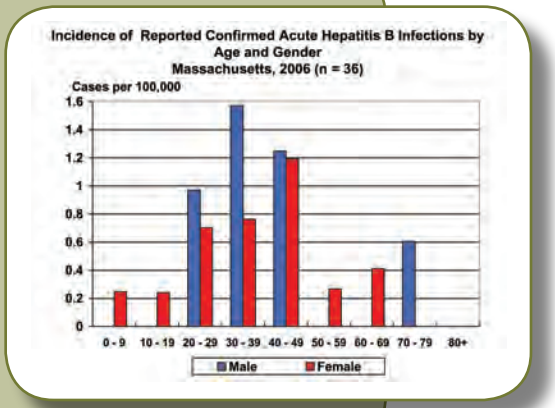


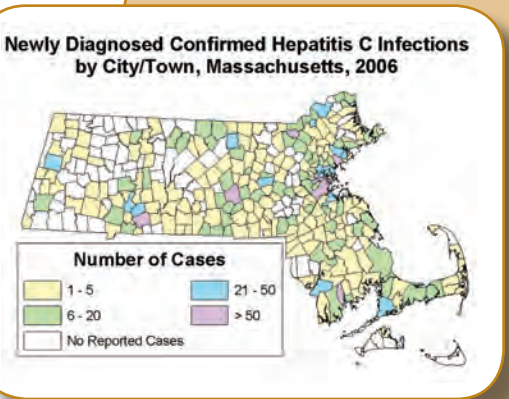


In 2006, 36 cases of confirmed acute hepatitis B infection were reported in Massachusetts. There was a 67% decrease in the number of acute hepatitis B cases reported from 2005 to 2006. This is the lowest number of cases reported since 2000. A peak of reported cases was observed in 2003, with 204 cases. The increase and subsequent decline in cases may have been the result of enhanced surveillance followed by a more restrictive case definition established by CDC.

In 2006, the highest incidence rate of acute hepatitis B among males was in the 30-39 year-old age group, and in females, in the 40-49 year-old age group.

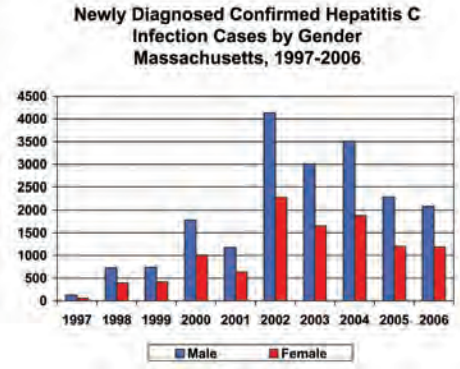
Of the total acute cases reported, 86% occurred in persons between ages of 20 and 49 years.

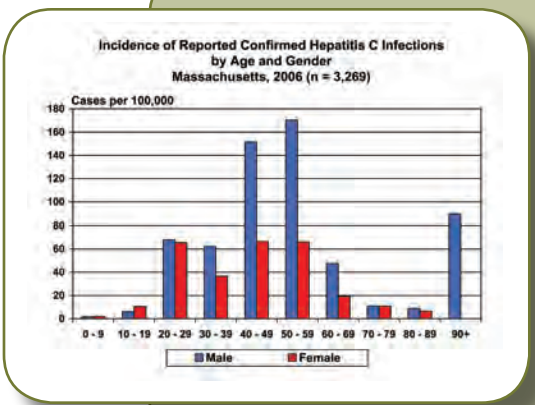




Overall there were 3,293 confirmed cases of diagnosed hepatitis C infection reported in Massachusetts in 2006. The highest concentrations of cases were in the urban areas of Boston, Worcester, and Springfield.

There was a 6% decrease in the number of reported, diagnosed, hepatitis C infection cases reported in 2006 compared with 2005. This is the lowest number of cases reported in a year since 2001.





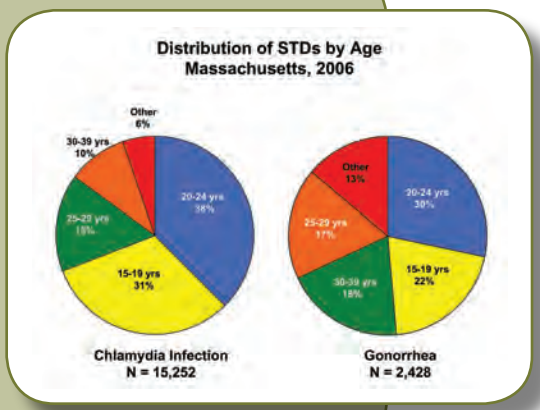
In 2006, the highest diagnosis incidence rate of reported hepatitis C among males was in the 50-59 year-old age group. In females, the 40-49 and 50-59 year-old age groups had the highest reported incidence rates.

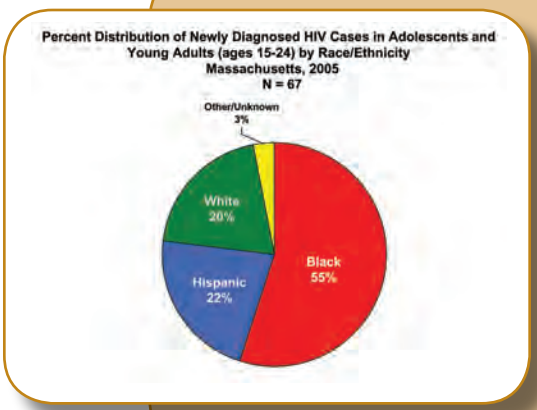
Of all acute hepatitis C cases reported, 58% occurred in persons between the ages of 40 and 59 years.

STDs IN ADOLESCENTS AND YOUNG ADULTS

Compared to older adults, sexually active adolescents and young adults are at higher risk for acquiring STDs. This higher risk is due to a combination of behavioral, biological and cultural factors. The higher prevalence of STDs among adolescents also reflects multiple barriers to quality STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality. (Source: CDC. *Sexually Transmitted Disease Surveillance, 2005.* Atlanta, GA: U.S. Department of Health and Human Services, November 2006.)

In 2006, 69% of reported chlamydia infection cases, and 52% of reported gonorrhea cases, were in adolescents and young adults (ages 15-24).

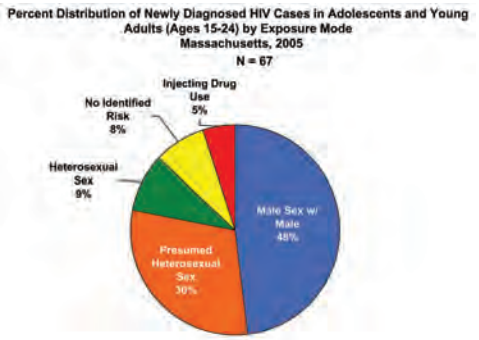




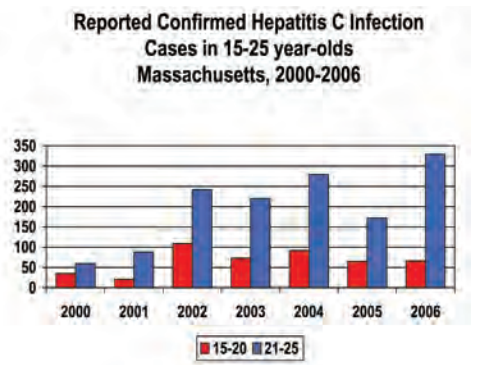
In 2005, reported, newly diagnosed HIV infections among adolescents and young adults in Massachusetts had the following racial/ethnic distribution: black (55%), white (20%), Hispanic (22%), and other (3%).

ADOLESCENTS & YOUNG ADULTS

In 2005, in Massachusetts, the primary modes of exposure for reported newly diagnosed HIV infection cases in adolescents and young adults were male with male sex (48%), presumed heterosexual (30%), heterosexual (9%), and injecting drug use (5%).



There has been a trend of increased HCV infection being reported in youth ages 15 to 25 years. From 2002 to 2006, the percent of total reported hepatitis C cases in 15-25 year-olds rose from 7% to 12%. Surveillance activities for this age group have been enhanced to address this trend. Early data indicate that the increase in cases may be due to increased injection drug use, particularly heroin.



SEXUAL BEHAVIORS AMONG MASSACHUSETTS HIGH SCHOOL STUDENTS BY GENDER, 2005

Source: Youth Behavioral Risk Factor Survey: **www.doe.mass.edu/cnp/hprograms/yrbs/**

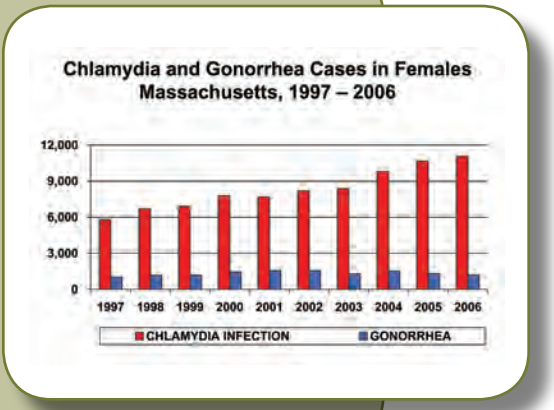
	Affirmative Responses (Percent)	
	Males	Females
Respondents: All Students		
Lifetime sexual intercourse	47.9	42.9
Sexual intercourse before age 13	8.1	2.2
Four or more lifetime sexual partners	14.5	10.5
Respondents: Students having sexual intercourse in past three months		
Recent sexual intercourse	32.7	35.4
Condom use at last sexual intercourse	71.6	59.2
Substance use at last sexual intercourse	26.2	20.2
Respondents: Students ever having sexual intercourse		
Ever been or gotten someone pregnant	8.2	10.4
Ever been diagnosed with HIV or STD	6.3	6.7

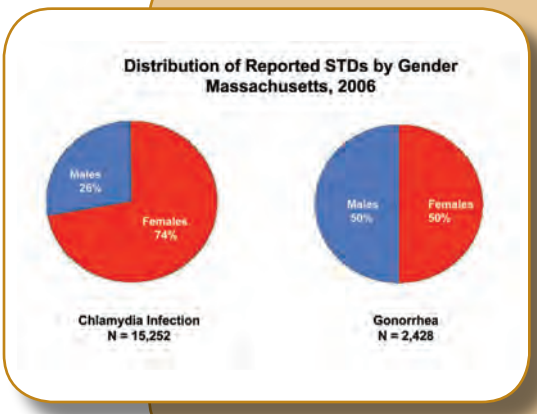
STDs AND WOMEN

Complications of STDs are greater and more frequent among women than men due to two primary factors. First, biologically, woman are more likely than men to become infected if exposed to an STD. Second, STDs are more likely to remain undetected in women, resulting in delayed diagnosis and treatment, and ultimately more untreated infections leading to complications. (Source: *The Hidden Epidemic*, Institute of Medicine, National Academy Press, Washington, D.C., 1997)

Untreated STDs in women can lead to serious health consequences, including pelvic inflammatory disease, infertility, ectopic pregnancy, and cervical cancer.

Compared to gonorrhea, reported chlamydia infection in Massachusetts is more common in women and has been increasing in the past ten years, in part due to increased adoption of recommended routine screening by healthcare providers.

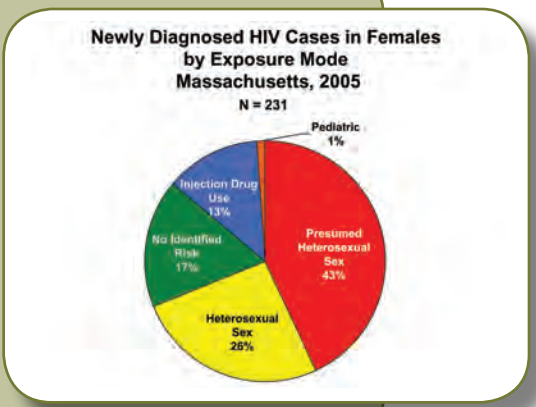


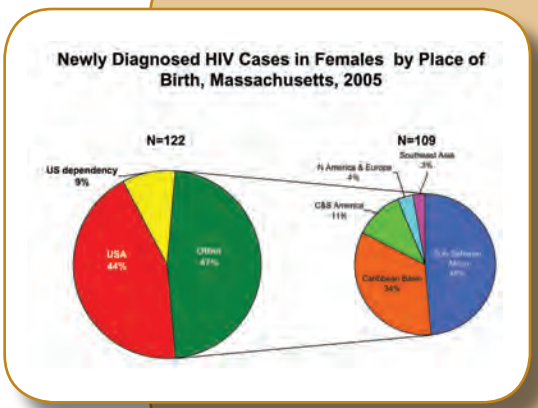


While gonorrhea cases are almost equally distributed between women and men, women are over-represented among chlamydia cases by a ratio of 3 to 1.

The greater number of chlamydia cases in women is attributable to increased screening in women as compared to men.

In 2005, the exposure modes for the 231 newly diagnosed HIV cases reported in women in Massachusetts was attributed to presumed heterosexual sex (43%), heterosexual sex (26%), no identified risk (17%), injecting drug use (13%), and pediatric exposure (1%).





In 2005, 47% of women reported with diagnosed HIV infection were born outside of the U.S. For men diagnosed in 2005, only 23% were born outside of the U.S.

Eighty-three percent of women diagnosed with HIV infection, who were born outside of the U.S., were born in regions of the world where heterosexual sex is the predominant mode of transmission of HIV infection.

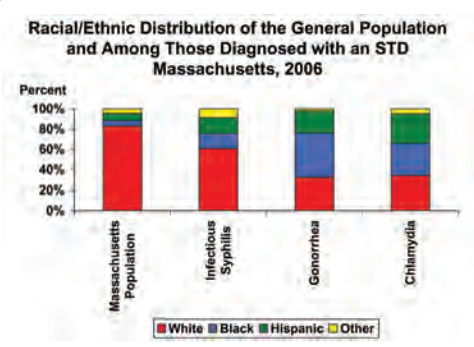
REPEAT CHLAMYDIA INFECTION IN WOMEN

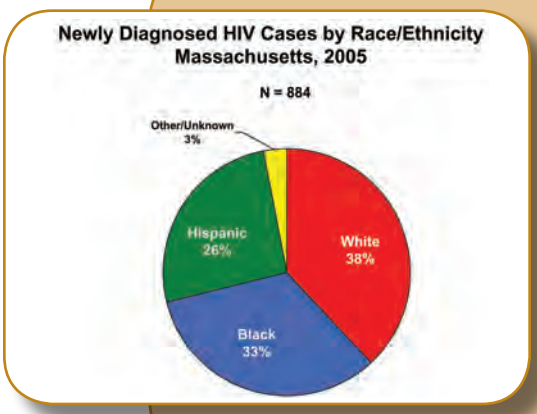
The CDC recommends re-testing women approximately 3 months after treatment for chlamydia infection (Source: CDC, Sexually Transmitted Diseases Treatment Guidelines. *MMWR* 55(RR-11), 2006). Findings from eight Massachusetts family planning clinics indicate that 25% of women who are treated for chlamydia infection are found to be re-infected with chlamydia when they are tested three to eleven months later. These findings suggest that many women are being re-infected by their untreated male partners.

RACIAL / ETHNIC DISPARITIES IN STD RATES

Ethnic minorities have traditionally had higher rates of reported STDs, which likely reflects limited access to quality health care, poverty, and higher prevalence of disease in these populations (Source: CDC. Trends in Reportable Sexually Transmitted Diseases in the United States, 2005). Available at http://www.cdc.gov/std/stats/trends2005.htm.

Although communities of color represent only 18% of the Massachusetts population, these communities bear a disproportionate burden of STDs. In 2006, 39% of the reported infectious syphilis cases, 68% of the reported gonorrhea cases, and 66% of the reported chlamydia infection cases occurred in individuals from communities of color.

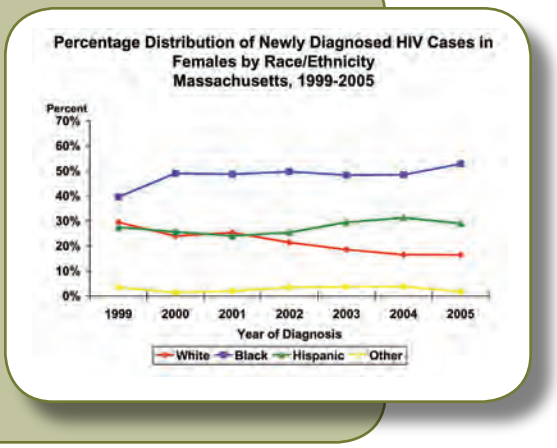


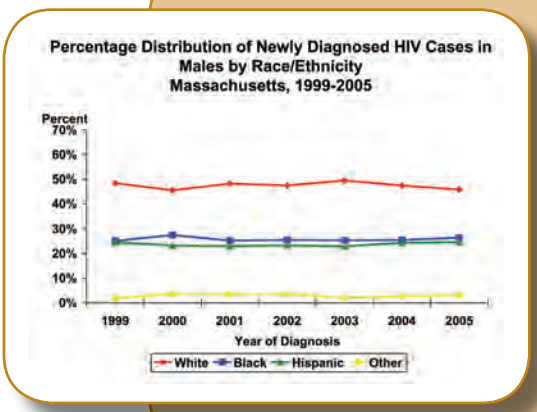


In 2005, the racial/ethnic distribution of reported, newly diagnosed, HIV infections in Massachusetts was as follows: white (38%), black (33%), Hispanic (26%), and other/unknown (3%).

RACIAL/ETHNIC DISPARITIES

In Massachusetts, black and Hispanic women bear a higher burden of HIV infection compared to women of other races/ethnicities.



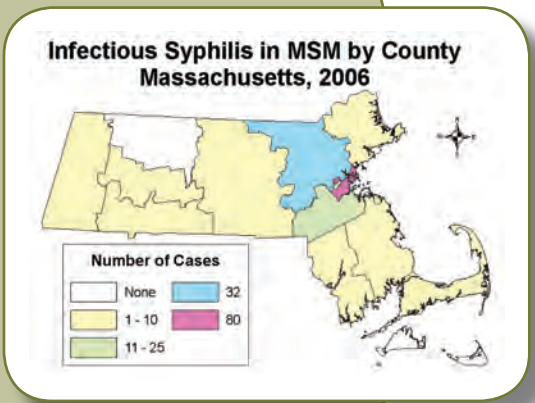


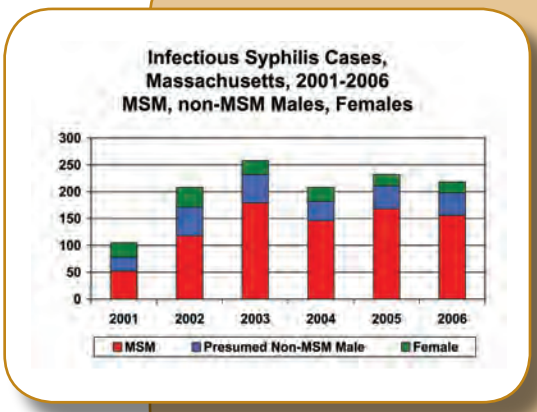
In Massachusetts, white men bear a higher burden of HIV infection as compared to men of other races/ethnicities.

STDs IN MEN WHO HAVE SEX WITH MEN

Data from several U.S. cities suggest that an increasing number of men who have sex with men (MSM) are acquiring STDs. Data also suggest that an increasing number of MSM are engaging in sexual behaviors that place them at risk for STDs and HIV infection. Because STDs and the behaviors associated with them increase the likelihood of acquiring and transmitting HIV infection, the rise in STDs among MSM may be associated with an increase in HIV incidence among MSM. (Source: CDC. *Sexually Transmitted Disease Surveillance*, 2005. Atlanta, GA: U.S. Department of Health and Human Services, November 2006.)

In 2006, there were 156 infectious syphilis cases in men who have sex with men (MSM) reported in Massachusetts, of which 80 (51%) were in Suffolk County.

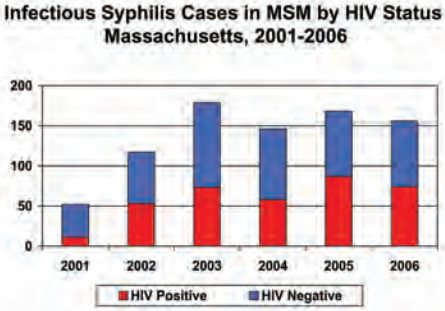




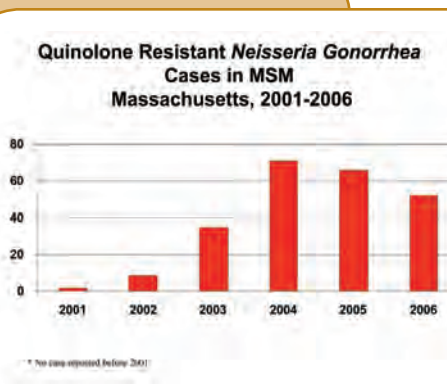
In the past six years, men who have sex with men accounted for the majority of infectious syphilis cases in Massachusetts, ranging from 50% in 2001 to 72% in 2006.

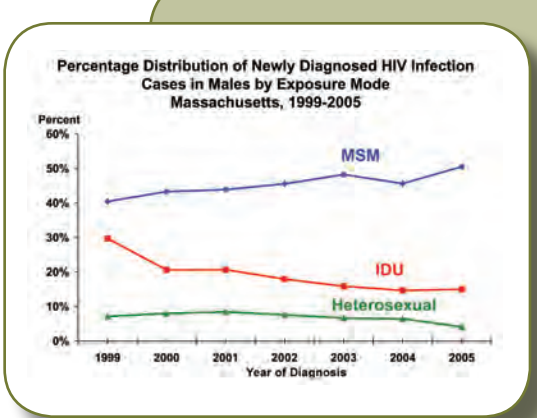
In 2006, the racial/ethnic breakdown of reported infectious syphilis cases in MSM was white (71%), black (9%), Hispanic (13%), other (2%), and unknown (6%). The median age of the cases was 41 years.

In 2006, 46% of the reported infectious syphilis cases in MSM occurred in HIV-positive individuals.



Results from the Quinolone Resistant *Neisseria Gonorrhea* (QRNG) Prevalence Project indicate a rise in quinolone-resistant gonorrhea in MSM in Massachusetts. The Project reported 2 QRNG cases in 2001 and 52 QRNG cases in 2006.





Among males, the proportion of reported HIV infection cases with male to male sex as the reported mode of exposure increased from 41% in 1999 to 51% in 2005. The number of newly diagnosed HIV cases in MSM increased from 311 in 2004 to 330 in 2005.

Summary of Strengths and Limitations of Data

	HIV/AIDS Case Data	STD Case Data	Viral Hepatitis Case Data
Description	• Collected by MDPH Bureau of Communicable Disease Control, HIV/AIDS Surveillance Program. • Reportable statewide. • All licensed healthcare providers and laboratories are required by law to report. • Cases of AIDS and HIV infection are currently reported by name, but HIV cases included in this report were reported by a code extracted from identifiers from 1999 through 2006.	• Collected by MDPH Bureau of Communicable Disease Control, Division of STD Prevention. • Reportable statewide. • All laboratories and healthcare providers are required by law to report nine STDs, including syphilis, gonorrhea, chlamydia infection, and lymphoma granuloma venereum.	• Collected by MDPH Bureau of Communicable Disease Control, Office of Integrated Surveillance and Informatics Services. • Reportable statewide. • All laboratories and healthcare providers are required to report laboratory indicators of hepatitis B and C infection.
Strengths	• Statewide reporting, population-based. • Risk information is available. • Completeness of reporting is high. • Comparable with other states.	• Statewide reporting, population-based. • Comparable with other states. • Enhanced reporting of positive laboratory results.	• Statewide reporting, population-based. • Enhanced reporting of acute cases, hepatitis B cases in child-bearing aged women and children and hepatitis C cases among youth ages 15-25.
Limitations	• Under-reporting (10%-15%) hampers interpretation of AIDS case data. • Not all AIDS cases are reported at time of diagnosis (reporting lag). • HIV data may be incomplete because some HIV-infected people may not have been tested or have entered care.	• Under-reporting of up to 10% of STD cases. • Race/ethnicity is missing in 31% of gonorrhea cases and 37% of chlamydia infection cases. • Reports are not received on those not seeking care or screening. • Bias is introduced for some STDs, such as chlamydia infection, where screening of asymptomatic persons occurs more frequently in women than in men.	• Race data are missing in 56% of confirmed acute hepatitis B and 80% of confirmed hepatitis C cases; ethnicity data are missing in 58% of acute hepatitis B and 75% of confirmed hepatitis C cases. • Risk history data is missing in a majority of reported hepatitis B and C cases. • Reports not received on those not seeking care.

Interpreting STD, HIV/AIDS and Viral Hepatitis Data

I. HIV/AIDS Exposure Mode Definitions

The HIV/AIDS exposure mode indicates the most probable risk behavior associated with HIV infection. Assignment of exposure mode is done in accordance with Centers for Disease Control and Prevention guidelines when multiple exposure modes are reported. Following is a description of the exposure mode categories:

- **MSM (Male to Male Sex):** Includes men who report sexual contact with other men, and men who report sexual contact with both men and women.
- **IDU (Injection Drug use):** Cases in persons who report injection drug use.
- **MSM/IDU:** Cases in men who report both injection drug use and sexual contact with other men.
- **Heterosexual Sex:** Cases in persons who report specific heterosexual sex with a person with, or at increased risk for, HIV infection (e.g. an injection drug user). The sub-categories for this mode of transmission are listed below.
    - *Heterosexual Sex w/ an Injection Drug User*
    - *Heterosexual Sex w/ a person w/ HIV infection or AIDS*
    - *Heterosexual Sex w/ Bisexual male*
    - *Other Heterosexual Sex*: Includes all other sub-categories of risk, such as heterosexual contact with a person infected through a blood transfusion.
- **Presumed Heterosexual:** Cases in persons who report heterosexual sex but do not report any other personal risk nor any knowledge of specific risk in their sex partners. Presumed Heterosexual is an exposure mode category used by the Massachusetts HIV/AIDS Surveillance Program. The Centers for Disease Control and Prevention (CDC) categorizes these cases as No Identified Risk.
- **Pediatric:** Infection before the age of 13 years, including mother to child transmission through pregnancy, childbirth or breastfeeding and blood transfusions to children.
- **NIR (No Identified Risk):** Cases in persons with no reported history of exposure to HIV through any of the listed exposure categories. Follow-up is conducted to determine risk for those cases that are initially reported without a risk identified.

II. Race/Ethnicity of STD and HIV/AIDS Cases

Race/ethnicity references to whites and blacks represent persons who are white non-Hispanics and black non-Hispanics, respectively. All references to Hispanic for race/ethnicity represent persons of Hispanic heritage regardless of race.

III. References to Newly Diagnosed HIV Infections

Newly diagnosed HIV infections/cases include all persons diagnosed with HIV in 2005, including those who were concurrently or subsequently diagnosed with AIDS.

STD, HIV/AIDS and Viral Hepatitis Contact Information

Division of STD Prevention, HIV/AIDS Surveillance, and Ratelle STD/HIV Prevention Training Center

Topic	Contact	E-Mail	Phone
Policy Development and Administration	Thomas Bertrand (Division Director)	Thomas.Bertrand@state.ma.us	617-983-6941
Sylvie Ratelle STD/HIV Prevention Training Center	Katherine Hsu (Medical Director) Janine Dyer (Coordinator)	Katherine.Hsu@state.ma.us Janine.Dyer@state.ma.us	617-983-6948 617-983-6964
STD/HIV/AIDS Surveillance and Epidemiology	Jim Murphy (Director) Yuren Tang (Epidemiologist)	James.Murphy2@dph.state.ma.us Yuren.Tang@state.ma.us	617-983-6577 617-983-6554
STD Clinical Services	Bill Dumas (Clinical)	Bill.Dumas@state.ma.us	617-983-6950
STD Disease Intervention Field Services and STD Partner Notification	Hillary Johnson (Director of Field Services)	Hillary.Johnson@state.ma.us	617-983-6951
STD Health Education, Training, and Prevention	Sheila Nelson David Goudreau	Sheila.Nelson@state.ma.us David.Goudreau@state.ma.us	617-983-6961 617-983-6835

HIV/AIDS Bureau

Topic	Contact	E-Mail	Phone
Policy, Planning, Resource Allocation, Research, and Evaluation	Kevin Cranston (Bureau Director) Deborah Isenberg (Director of Research and Evaluation) Thera Meehan (Director of Policy and Planning) Tammy Goodhue (Director of Training and Health Communication)	Kevin.Cranston@state.ma.us Deborah.Isenberg@state.ma.us Thera.Meehan@state.ma.us Tammy.Goodhue@state.ma.us	617-624-5303 617-624-5311 617-624-5328 617-624-5338
Administration and Finance, Personnel, Contracts and Procurement, Budget	Bob Carr (Deputy Bureau Director) Ceci Dunn (Director of Operations)	Bob.Carr@state.ma.us Ceci.Dunn@state.ma.us	617-624-5317 617-624-5370
Consumer Office	Sophie Lewis (Director of Consumer Office) Paul Goulet (Consumer Office Coordinator)	Sophie.Lewis@state.ma.us Paul.b.Goulet@state.ma.us	617-624-5366 617-624-5389
Prevention and Education	Barry Callis (Director of AIDS Prevention and Education)	Barry.Callis@state.ma.us	617-624-5316
HIV Clinical Care, Home-Based HIV Care, HIV Counseling and Testing, Corrections-Based HIV Services	Brenda Cole (Director of Health Services)	Brenda.L.Cole@state.ma.us	617-624-5333
HIV Client Services,Case Management, Peer Support Services, Housing Support Services, Service Coordination Collaboratives	Linda Goldman (Director of Client Services)	Linda.Goldman@state.ma.us	617-624-5347

Viral Hepatitis Program

Topic	Contact	E-Mail	Phone
Viral Hepatitis Program	Daniel Church (Hepatitis C Coordinator) Clare O'Donoghue (Contract Manager)	Daniel.Church@state.ma.us Clare.O'Donoghue@state.ma.us	617-983-6800 617-983-6866
Hepatitis Surveillance and Epidemiology	Franny Elson (Epidemiologist) Shauna Onofrey (Epidemiologist)	Franny.Elson@state.ma.us Shauna.Onofrey@state.ma.us	617-983-4382 617-983-6776

STD, HIV/AIDS and Viral Hepatitis Resources

Division of STD Prevention, HIV/AIDS Surveillance, and Ratelle STD/HIV Prevention Training Center

Training

Professional training to community based organizations, local public health departments, and medical providers can be requested and is free of charge.

Type of Training	Contact Information and Website
STD Education, STD Partner Notification, and STD Reporting	617-983-6940 www.mass.gov/dph/cdc/std
HIV/AIDS Reporting and Surveillance Projects	617-983-6560 www.mass.gov/dph/cdc/aids
HIV/AIDS Provider Trainings	508-752-7313 www.mass.gov/Eeohhs2/docs/dph/aids/prov_training_calendar.pdf
Viral Hepatitis Education	617-983-6800 http://www.mass.gov/dph/cdc/epii/imm/imm.htm
STD/HIV Diagnosis, Treatment, and Management	617-983-9645 www.mass.gov/dph/cdc/stdtcmai/courses.htm

Material and Clinical Toolkits

Health education materials and clinical toolkits can be requested free of charge.

Material	Contact Information and Website
STD, HIV, Viral Hepatitis Fact Sheets	617-983-6940 or 617-624-5338 www.mass.gov/dph/cdc/factsheets/factsheets.htm
HIV/AIDS Reporting for Health Care Providers Brochure	617-983-6560 www.mass.gov/dph/cdc/aids/hiv_report_for_health_care_providers.htm
Viral Hepatitis Posters and Brochures	617-983-6800 www.mass.gov/dph/cdc/epii/hepatitis/hepa.htm or www.mass.gov/hepc
STD/HIV Diagnosis, Treatment, and Management Toolkits	617-983-9645 www.mass.gov/dph/cdc/stdtcmai/stdtcmai.htm

MDPH and Bureau Funded Websites

Division of STD Prevention	www.mass.gov/dph/cdc/std
HIV/AIDS Bureau	www.mass.gov/dph/aids
HIV/AIDS Surveillance	www.mass.gov/dph/cdc/aids
Viral Hepatitis Program	
Hepatitis C	www.mass.gov/hepc
Hepatitis A	www.mass.gov/dph/cdc/epii/hepatitis/hepa/htm
Sylvie Ratelle STD/HIV Prevention Training Center	www.mass.gov/dph/cdc/stdtcmai/stdtcmai.htm
GetTestedBoston (for MSM)	www.gettestedboston.org
URhealthstyle (for Urban Teens)	www.URhealthstyle.com

National Websites

Center for Disease Control and Prevention	www.cdc.gov
Division of STD Prevention	www.cdc.gov/std
Division of HIV/AIDS Prevention	www.cdc.gov/hiv
Division of Viral Hepatitis	www.cdc.gov/ncidod/diseases/hepatitis
National Network of STD/HIV Prevention Training Centers	www.stdhivpreventiontraining.org